Written Testimony of

Consumers Union

on

Medicare Premium Support Proposals

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Introduction

Consumers Union, the policy and advocacy arm of Consumer Reports[1], appreciates this opportunity to provide written testimony on Medicare premium support proposals currently being considered as an alternative to traditional Medicare.

Medicare provides essential health coverage for almost 50 million American seniors and persons with disabilities. Medicare faces financial challenges, primarily as a result of increasing enrollment due to retiring baby boomers. Importantly, however, Medicare per enrollee spending has been slightly *below* that of private insurance.[2]

Premium support proposals seek to transform Medicare from a defined benefit program, in which beneficiaries are guaranteed coverage for a fixed set of benefits, to a defined contribution or "premium support" program, in which beneficiaries are guaranteed a fixed federal payment (or voucher) to help cover their health care expenses.

Consumers Union believes that this approach to addressing the real financial challenges to Medicare will not reduce overall health care costs, but will put millions of senior and disabled Americans at greater risk of higher costs, less coverage, or both.

Unacceptable Transfer of Risk to Beneficiaries

Under these proposals, a large amount of risk is transferred to Medicare beneficiaries.

Beneficiaries are at risk for the escalation of medical costs above Gross Domestic Product (GDP) +.5 percent. There are no guarantees that the proposal will hold down per capita cost growth. Instead, we argue below that cost control is unlikely, and thus is likely to increase costs for Medicare beneficiaries, most of whom. live on modest, fixed incomes and are not in a position to pay much more for their health care.

In addition to this financial risk, in a world of multiple and varying plan designs beneficiaries are at risk for being able to identify the plan that provides the best coverage. The "premium support" proposals will require health plans to offer coverage that is "actuarially equivalent" to today's Medicare Fee-for-Service (FFS) plan. This means that the Medicare benefit design would no longer be standardized, requiring beneficiaries to

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[1] Consumer Reports is the world's largest independent product-testing organization. Using its more than 50 labs, auto test center, and survey research center, the nonprofit rates thousands of products and services annually. Founded in 1936, Consumer Reports has over 8 million subscribers to its magazine, website, and other publications. Its advocacy division, Consumers Union, works for health reform, food and product safety, financial reform, and other consumer issues in Washington, D.C., the states, and in the marketplace.

[2] John Holahan and Stacey McMorrow, "Medicare, Medicaid and the Deficit Debate: Timely Analysis of Immediate Health Policy Issues", Urban Institute, April 2012.

understand how countless complex designs would affect them. There is overwhelming evidence that consumers have difficulty understanding and comparing the cost-sharing provisions of health plans.[3] We must recognize that these products are not cans of soup that can be easily compared, especially with new and "innovative" products coming on the market. Innovation is often accompanied by additional complexity for consumers.

Some proposals promise to provide voucher recipients with 'clear and easy to understand information' on various plans. Health plans, the National Association of Insurance Commissioners (NAIC) and consumer assistors everywhere have been trying to convey understandable information on health plan features for years. Indeed, several regulations require that various health plan summaries be understandable to the average health plan enrollee. However, we have *no* evidence thus far that these are successful.[4] The reasons vary: the underlying information is complex and new methods of usefully summarizing are only just coming online.[5] In short, these proposals put seniors at risk of obtaining coverage that they do not understand and that does not cover their needs.

Harnessing Market Forces – How Realistic?

Harnessing market forces to achieve the policy goal of adequate health coverage for seniors in a financially sustainable method is a theory that needs a careful reality check.

As some of the proposals recognize, harnessing competition among private insurance plans to achieve a policy goal takes aggressive government intervention and oversight. The market cannot operate unfettered because certain outcomes, such as engaging in risk selection or discriminatory plan designs, are a natural by-product of private insurance company activity. Yet these practices undermine the policy goals of adequate, affordable coverage for all seniors.

Experience with the Medicare Advantage program shows us how hard it is to get this oversight right. Rules governing benefit design, marketing and other practices have had to be continuously fine-tuned due to private insurer predilections to attract the healthiest risks.

Policy approaches that "harness the market" require rules with respect to consumer protections, monitoring and enforcement.. We can expect that in all these activities

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[3] Ted von Glahn. "Consumer Choice of Health Plan Decision Support Rules for Health Exchanges", Pacific Business Group on Health, February 2012. Lynn Quincy. "What's Behind the Door: Consumers' Difficulties Selecting Health Plans", Consumers Union, January 2012.

[4] Colleen E. Medill, EBRI Fellow, Richard L. Wiener, Brian H. Bornstein, and E. Kiernan McGorty, "How Readable Are Summary Plan Descriptions For Health Care Plans?", EBRI Notes, October 2006. This study found that the average readability level for important information concerning eligibility, benefits, and participant rights and responsibilities in summary plan descriptions is written at a first year college reading level, despite a requirement that the materials be understandable to the average plan enrollee.

[5] The Kleimann Group and Consumers Union, "Early Consumer Testing of the Coverage Facts Label", August 2011.

insurers and other interested parties will try to affect rules at the state and federal level to ensure that more advantage falls their way, to the detriment of sicker patients.

Little Evidence That Costs Would Be Lower

Proponents argue that the premium support approach can be used to lower health care costs, compared to traditional Medicare. This must be examined critically from three perspectives.

One, it is not just federally financed costs that need to be considered but overall costs, including the consumer's out-of-pocket share. Merely shifting costs to consumers is not an acceptable policy solution. The Congressional Budget Office (CBO) projects that *total* health care spending for a typical beneficiary covered by the standardized benefit under at least one of the proposals would grow faster than such spending for the same beneficiary in traditional Medicare.[6]

Two, the ingredients for a competitive market place - one capable of driving down prices - are missing. As discussed above, consumers have tremendous difficulty distinguishing among health plans – a key requirement for a functioning marketplace. Consumers also lack the necessary price transparency, ability to evaluate alternate treatments and confidence to make market driven decisions when consuming health care services. For serious medical conditions, most consumers defer to the treatment recommended by their doctors. And as mentioned above, effective risk adjustment mechanisms and understandable health plan disclosures that are key to this type of approach need to be greatly improved.

Three, there is little evidence that costs would be lower. The CBO estimates that a private health insurance plan covering the standardized benefit would be more expensive currently than traditional Medicare.[7] This should not be surprising. The Medicare Advantage program – a market-based alternative to traditional Medicare – costs more, not less, per beneficiary.[8] Those fixed monthly payments to Advantage plans are, on average, 13 percent above Medicare FFS costs.[9]

More broadly, private plans operating in the commercial market place now have provided little evidence that they can lower costs more successfully than Medicare's current approach.

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6 Elmendorf, April 5, 2011 letter to Honorable Paul Ryan, http://cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan_letter.pdf

[7] Ibid.

[8] The Medicare Advantage program shares many of the same features of the premium support program. The plans must offer a benefit that is actuarially equivalent to Medicare. They face anti-discrimination rules and receive risk adjusted payments from CMS. Costs for extra benefits are borne by beneficiaries. Despite these program features, costs are higher in the Medicare Advantage program.

[9] Brian Biles and Grace Arnold, "Medicare Advantage Payment Provisions: Health Care and Education Affordability Reconciliation act of 2010 H.R. 4872", George Washington University School of Public Health, March 2010.

Medicare's Financial Challenges Can Be Addressed

We can all agree that Medicare finances need attention. However, experts agree that there are multiple ways to address Medicare's financing gap.

For example, there is wide-spread agreement that adopting measures such as reducing the use of redundant or unnecessary tests, reducing the use of treatments that evidence shows are not effective, increasing the use of generic drugs, and increasing the effectiveness and use of preventive care can all reduce cost-growth. The Affordable Care Act introduces numerous pilots designed to alter provider incentives to reduce the use of the unnecessary services.

As we wait for the evidence from these pilot programs, numerous other proposals have been offered to achieve the savings needed, such as extending Medicaid drug rebates to Medicare dual eligibles.[10] Many experts believe that significant savings could be obtained if Medicare is allowed to negotiate drug prices. Current law bars the Centers for Medicare and Medicaid Services (CMS) from negotiating the prices for drugs. This is in stark contrast to the Veteran's Administration (VA), which negotiates directly with drug manufacturers and is not bound by the same formulary rules as Medicare Part D prescription drug plans.[11]

Greater Choice For Beneficiaries

Another argument often made for premium support proposals is that beneficiaries will benefit from greater choice. Decision-makers must critically examine and reject this oft made argument. The research literature is clear that while a few choices are good, too much choice undermines consumer decision-making.[12] As cognitive function declines, it becomes even more difficult to navigate multiple choices.

In summary, Consumers Union can not support moving Medicare in the direction of the private commercial insurance market, which is more expensive, has higher administrative costs and would put Medicare beneficiaries at much greater risk. There are numerous

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[10] Robert A. Berenson and John Holahan, "Preserving Medicare: A Practical Approach to Controlling Spending", the Urban Institute, September 2011.

[11] Frakt, AB, ,S. Pizer and R. Feldman. "Should Medicare adopt the Veterans health administration formulary?", *Health Care Financing & Economics*, May 2012.

12 Yaniv Hanoch et al., "Choice, Numeracy, and Physicians-in-Training Performance: The Case of Medicare Part D", *Health Psychology*, July 2010; Stacey Wood et al., "Numeracy and Medicare Part D: The Importance of Choice and Literacy for Numbers in Optimizing Decision Making for Medicare's Prescription Drug Program" *Psychology And Aging*, June 2011; J. Michael McWilliams et al., "Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those With Impaired Decision Making", *Health Affairs*, September 2011.

other steps that could be taken to help shore up the Medicare Trust Fund while working to address the broader cost issues that affect all of the health care sector.

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